

Employee Reimbursement Account Direct Deposit Authorization Form Instructions

To enroll in Direct Deposit, please read the back of this form and fill in the information requested in Section A. Then take or mail this form to your Financial Institution. The financial institution will verify the information in Section A and complete Section B. Return the completed form to Employee Benefits Cooperative(EBC). For further information, call 800-346-2126. **BE SURE TO THOROUGHLY READ THE BACK SIDE OF THIS FORM.**

TYPE OF TRANSACTION: New Change Cancel

Section A, please print, (to be completed by employee)

Employee Name(last, first, middle initial)	Type of Account Select One <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Address	Social Security Number
City, State, Zip Code	Telephone Number Home() _____ Work () _____

Depositor Certification

I certify that I have read and understand the back of this form. In signing this form, I authorize my Section 125 Health Care FSA expense, Dependent Care FSA, or Individual Premium Account reimbursements to be sent to the financial institution named below to be deposited in the designated account.

Signature _____ Date: _____

Joint Account Holders Certification

Signature _____ Date: _____

Section B (to be completed by financial institution)

Name and Address of Financial Institution	Routing Number/Transit Number
	Account Title
	Account Number

Financial Institution Certification

I confirm the identity of the above named employee and joint tenant, if any , and the account number and title as representative of the above named Financial Institution. I certify that as a Member of an Automated Clearing House, this financial institution agrees to receive and deposit reimbursements to the account shown above, in accordance with the policies of this financial institution.

Print or Type representative's Name	Signature of Authorized Representative
Telephone: _____	
Date: _____	

When mailing your direct deposit authorization form. **Please attach a copy of a voided check.** If faxing to EBC, provide a copy of a voided check also.

Participants in EBC's BEST flex Health Care FSA, Dependent Care FSA, and Individual Billed Premium accounts have the option to have their authorized reimbursements deposited directly into their personal checking or savings account. It is an optional convenience called Direct Deposit. If you have any questions regarding your electronic transfers, call EBC customer service Department at 1-800-346-2126 (long distance) or 1-608-831-8445 (local).

Conditions of Participation include:

- Your financial institution must be a member of an Automated Clearing House.
- If you decide to enroll in Direct Deposit, you and your financial institution must complete the authorization form.
- If your account is a joint account, the authorization form must be completed by both parties holding the joint account.
- If you wish to cancel your participation in Direct Deposit you must complete another authorization form. Once you cancel, you may not re-enroll in Direct Deposit until the open enrollment period of the next plan year. This rule may be waived in unusual situations.
- It is your responsibility to notify us immediately of any changes in your financial institution (i.e. change of account number, closure of account, etc.) To notify us of the change, use the Direct Deposit authorization form. Mark the Change box in the Type of transaction entry. We will process these changes immediately upon receipt of the form. Authorization forms may be faxed to EBC in case of emergency. Since changes of this type usually take 2-3 weeks to complete, please plan accordingly.
- Your electronic transfer will be made directly into your account. If this transfer cannot be made within three business days of receipt by your financial institution, EBC will investigate, then issue and mail a reimbursement check to you, if requested. Pending resolution of the electronic transfer problem, you will continue to receive reimbursement check in the mail. Reinstatement in Direct Deposit will be determined on a case-by-case basis and you will be notified.
- The agreement represented by this authorization will remain in effect from one plan year to the next until you cancel it. To cancel, you must complete a new Direct Deposit Authorization form as a cancel transaction.
- This agreement may also be canceled by your financial institution. In such cases, you will receive reimbursement check in the mail.

Mail this form to:

Employee Benefits Cooperative
P.O. Box 44347
Madison, WI 53744-4347

Or Fax to:

(608) 831-1159

Be sure to attach your voided check